Practice-based, Guided Self-assessment for Improved Patient Care: Performance Improvement CME

Jeanne G. Cole, MS
Director, Office of CME
Jefferson Medical College

The ability to maintain and update knowledge and skills in a self-directed manner is one of the hallmarks of the profession of medicine.[1,2] However, over recent years, the ability of physicians to accurately self-assess and effectively self-direct their continuing professional development has been called into question as patient safety and quality concerns rise to the forefront.[3,4]

Performance Improvement CME (PI CME) is a new vehicle recently approved by the American Medical Association through which CME providers can award the *American Medical Association* (*AMA) Physician's Recognition Award (PRA) Category 1 Credits* ™. PI CME represents a different approach to continuing professional development, and marks a departure from traditional CME activities. PI CME is based on a continuous cycle of improvement and calls for a formalized approach to change and practice behavior.[5] It draws on practice-based data to assist physicians in understanding actual performance patterns in practice, and provides the data to guide physician self assessment of performance.

A PI CME activity consists of three distinct stages, each of which is valued at five (5) *AMA PRA Category 1 Credits*™. Stage A is designed to aid physicians in reviewing their performance in an area of practice that might benefit from closer assessment. In this stage, data about physician compliance with a specified performance measure is developed from actual practice data. Physicians are expected to review these data and make determinations about how well they perform on the measure. Reflection on how to address changes that may be indicated by the data is expected to lead to an action plan to foster change and improvement. Specific, measurable objectives for change and improvement are expected. The second stage, Stage B, consists of participating in the planning and/or implementation of evidence-based changes in practice using materials identified or developed in response to the data from Stage A. Key to this stage is the implementation of a planned change over time. Finally, in Stage C, the effectiveness of the changes implemented in Stage B is assessed, and data generated to compare against the practice-based data from Stage A. Participants who complete all three stages in sequence may

claim an additional five (5) credits for a total of up to 20 *AMA PRA Category 1 Credits* ™. *(*http://www.ama-assn.org/ama/pub/category/15889.html *).*

The guided data review feature of PI CME is important given the reports in the literature that unguided individual self assessments have been found to be inaccurate when compared to actual performance measures.[3] It appears that in the world of self-assessment, we all may be citizens of "Lake Wobegon"—considering ourselves above average.[6] In fact, as reported by Kruger and Dunning [7], not only do people tend to overestimate their abilities when asked to self assess, those whose actual performances are in the bottom quartile overestimate their abilities to a greater degree than others. This finding has been reproduced in a number of other studies, and it is now accepted that individual self-assessment skills/abilities, when referenced against some outside measure, are seldom accurate predictors of performance. So, what does this mean for the practicing physician and the profession of medicine? The traditional assumption that the physician in practice can effectively self assess and select appropriate continuing education activities to maintain and extend their knowledge and skills is being questioned. [2] This questions one of the core values of a self regulating profession. However, new approaches are emerging, as evidenced by the American Board of Medical Specialties' (ABMS) Maintenance of Certification requirements (http://www.abms.org/About_Board_Certification/MOC.aspx) with its emphasis on lifelong learning, self assessment and practice based needs assessment. New types of CME are being developed that encourage performance improvement activities that are based on individual clinical practice data. These changes are not confined to the continuing medical education stage of the medical education continuum; the Accreditation Council for Graduate Medical Education's (ACGME) Outcomes Project (http://www.acgme.org/outcome/) establishes practice-based performance improvement and lifelong learning within its core competencies for training residents, and the Liaison Committee for Medical Education (www.lcme.org) places similar emphasis on learning from clinical practice and establishing the habits of lifelong learning in the medical student stage of medical education.

Jefferson is in the forefront of developing PI CME in both inpatient and outpatient practices. On the inpatient side, a pilot project gathered data from the electronic health record used by anesthesiologists in Jefferson's operating rooms to assess anesthesiologists' compliance with protocols for timely administration of antibiotics, an important practice in reducing surgical site infection rates. Analysis of practice data revealed room for improvement in compliance

rates (Stage A), resulting in the development and delivery of an educational intervention for the participants in the pilot project (Stage B). In early spring 2007, we will review current compliance rates to assess the success of the PI CME project (Stage C). By completing the three stages in sequence, participants will each have earned 20 *AMA PRA Category 1 Credits* ™ (5 for each stage plus 5 for completing the project), and, hopefully, improved compliance rates ultimately will result in lower infection rates.

On the outpatient side, the Office of CME, Department of Health Policy and JUP Clinical Care Committee have been collaborating to pilot a PI CME activity to examine the adequacy of chart data in the outpatient psychiatry practice at the University. Just launched, this PI CME project is centered on a chart audit to assess the presence of significant clinical data in the psychiatrists' outpatient charts. The chart audit data (collected by the physician) are being incorporated into a database. Analysis will aid in the development of strategies to improve adequacy and consistency of patient chart data across the practice. Educational interventions will be designed and implemented, and charts will be re-audited after six months, thus completing the three stage model. Through the JUP Clinical Care Committee, each clinical group outpatient practice at the University is developing performance improvement cycles. We expect to be able to award PI CME credit for many of these as we refine our model and processes, and more projects become eligible for this type of credit. For more details on the Jefferson activities visit:
http://jeffline.jefferson.edu/jeffcme/office/presentations/SACMEPMSPOSTERfinal.pdf

Checking with ABMS specialty boards and their related professional associations may help you locate relevant resources to find out more about PI CME programs available in your area.

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